

	ACNE	ROSACEA	PERIORAL DERMATITIS
Def	chronic inflammatory disease of the pilosebaceous follicles , characterized by the formation of comedones , erythematous papules and pustules , less frequency nodules or cysts and in some cases scarring.	chronic inflammatory eruption of the flush areas of the face .	Is a chronic papulopustular facial dermatitis.
Etiology	four factors : ■ excessive production of P.S.gland sebum. ■ Obstruction to outflow of this sebum.. Inflammation due to leakage of contents of the P.S follicle into dermis. Excessive colonization or infection of the pilosebaceous(P.S) ducts with. • propionibacterium acnes and • staphylococcus epidermidis. ✗ Behaviors--wear headband⇒ contact acne(acne venenata) ■ Excessive face washing. ■ consum low diatry fat /chocolate!!! ✗ Hormones:- androgen,cortisole.	Etiology: unknown Predisposing factor: 1-Drugs:topical steroid 2-cosmetic 3-Physical factors: Uv light,heat. 4-microbiologic factors 5-hormonal factors. 6-Gastrointestinal disturbance. 7-focal infection may be the cause of some of the pustular types of Rosacea. 8-Hypertension. 9-Demodex folliculorum mites	Etiology: unknown. Predisposing factors: 1-Drugs:topical steroid 2-cosmetic 3-Physical factors:Uv light,heat. 4-microbiologic factors 5-hormonal factors. 6-Gastrointestinal disturbances.
Clinical features	Patient:- after puberty (but may 1st at 25y) Skin Lesion. ■ early lesions(lry) ⇒ open (blackheads) comedones (melanin in sebum oxidized by air) and closed (whiteheads)comedones=(non-inflammatory acne) ■ ⇒may develop into papules and pustules=(moderate inflam. Acne) ⇒may into nodules ,cysts ,may scar if follicle rupture)(severe inflam. Acne) Site:- mild cases:- mainly on the forehead, nose, and chin . ■ severe cases ⇒ May entire face (except periorbital skin) , upper chest and back . ■ Generally, it associated with clinical signs of excessive sebaceous secretion and a greasy Facial skin and scalp.	Patient :- women between ages 30 and 50 , fair hair, 182 skin color types. Skin Lesion:- erythema(flushing), papules, pustules, telangiectasia, and hypertrophy of the sebaceous glands. Localization:nose ,cheeks-brow and chin (eyelid and eyes may involved.) -may be superimposed on seborrhea. ■ Rhinophyma is characterized by(hypertrophic,hyperemic,large nodular masses centered around the tip of the nose) as a result of fibrosis,sebaceous gland hyperplasia and telangiectases. <u>Rhinophyma is almost exclusively a disease of men.</u>	Patient:- young women skin lesions grouped follicular reddish papules,papulovesicles, And papulopustules on an erythematous base . Localization:perioral area, nasolabial fold.
Variant	■ -Steroid acne:- pt. on systemic steroid therapy. ■ -Acne neonatorum:- spontaneous Resolve ■ -Cosmetic Acne:- mostly white head ■ -Acne conglobata : (most severe form of Acne Vulgaris) - men > women. multiple inflammatory nodules and cyst.(nodulocystic) ■ - Acne fulminans:(Acute febrile ulcerative acne) is acne conglobata which ass. with - fever, anorexia,malaise, leukocytosis - polyarthropathy , bone pain. - Common on Back +@chest(face uninvolved) ■ -Tropical Acne: see ⇒⇒⇒⇒⇒⇒↗↗	Types of Rosacea: 1-Steroid Rosacea 2-Ocular Rosacea (Ophthalmic Rosacea) 3-Rosacea conglobata. 4-Rosacea fulminans. 5-Familial Rosacea (Haber syndrom) ----- ← ← ✓ ■ -Tropical Acne: (unusual, severe form of acne). misdiagnosed as superficial folliculitis.. nodullar,cystic and pustular lesions occurring chiefly on the back, buttocks, and thighs. usually in older patients.	
	Acne images	Rosacia↓ and rhinophyma↓↓.	Perioral dermatitia↓↑



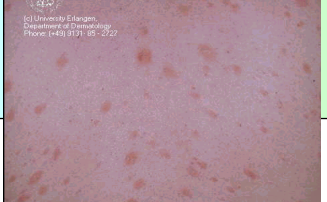
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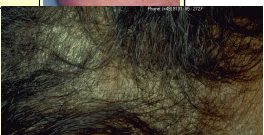
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Differential dx (dd) + Treatment (TT)	DD: ■ Comedonal -black head⇒ No diff.Dx. (characteristic) -white head⇒ - milia - falt wart. - contact acne - osteoma cutis ■ Papules & pustules Face ⇒ - folliculitis - pseudofolliculitis. -perioral dermatitis - Rosacea Trunk ⇒Malassezia folliculitis. -pseudomon. F. ■ Nodulocystic ⇒	DD: 1- Acne vulgaris 2- LE 3- cont- dermat- 4-photosensitivity 5-perioral derm- ■ Rhinophyma ⇒-Lupus vulgaris - lupus pernue!(sarcoidosis) -insect bites -leishman. @ 2ry bacterial infection TREATMENT: ■ Syst-: 1.Tetracycline long-term 4x250 mg 2months ■ Topical: Metronidazole (metroza gel) ■ Surgery :for Severe rhinophyma . <u>Topical steroids are positively contraindicated</u> (if pt. On steroid Taper it not stop suddenly--avoid flare)	DD: - Acne Vulgaris -Cont- derm- - Rosacea - Seborrhic D. (if NL Fold) Sycosis barbe in male. - Melasma. - G-ve folliculitis. TT: ■ Syst-antibiotics: Tetracycline ■ Topical:metronidazol (metroza gel) ■ Note(Topical steroids are positively contraindicated). ...
Acne treatment	■ (comedonal) acne ⇒ Topical agent ■ benzoyl peroxid • Topical antibiotics-erythro or tetra • topical vitamin A acid (Retin A) ■ Inflammatory(papule,pustules) :- Topical ABs(dr. solution) • not give Topical keratolytic , unless after time of AB useage,for short period). ■ A.conglobata :- • Isotretinoin (Roaccutane) 5-10mg post acne vulgaris • -keratolytic (salicylate acid,...retin A) Acne with PCO • Hormonal therapy:Diane 35 ⇒ women(hirsutism,dysmenorhea,Acne vulgaris) post acne scaring-- • Laser(best) ,Dermabrasion • Don't use systemic AB. @ isotritinoin simultaneously->hypotension(fitz.pseudotumor cerebri) • Not use systemic ABs @ Diane 35 simultaneously.		
	TT: of acne(pretest,fitz) ■ MILD (comedonal) acne ⇒Topical agent ■ benzoyl peroxid(BPO)/salicylic acid ■ Topical antibiotics-erythromycin and tetracycline, compined e BPO ■ topical vitamin A acid (tretinoin,adapalene,tazarotene) ■ Moderate (papule,pustules) :- Topical ABs -azaleic acid preparations -Skinoren(safe for pregnant) (Now isotretinon can be used to moderate acne if there is no contraindication) ■ Severe (Nodulocystic)/A.conglobata :- • Systemic Antibiotics- - Tetracycline 500-1500mg/day on empty stomach - Doxycycline50-100mg/kg twice daily,at bed time(can e food,but phototoxic S.E) - Azithro250-500mg po. 3times/wk (limited to pregnant &child <9years) • Isotretinoin (Roaccutane) restricted for severe or persistent cases..teratogenic(now for moderate acne)	Acneform drug eruption(قال نذاكره د.عادل)	



PSORIASIS	Psoriasis الصدفية	Lichen Planus الحزاز	Pityriasis rosea النخالة الوردية
DEF.	Is a common , chronic ,recurrent inflammatory disease of the skin characterized by(Classic lesion) round ,well-circumscribed , erythematous ,dry ,scaling plaques of various sizes. covered by grayish white / silvery white , thick* ,imbricated, & (easily removed*) lamellar scales .	Lichen planus: is a common , pruritic , inflammatory disease of the skin ,hair follicles ,and mucous membranes .	Self-limiting disorder characterized by the development of Asymptomatic erythematous scaling macules on the trunk .
ETIOLOGY	:unknown but theories ■ Genetic of psoriasis:(1/3 pt. +ve family hx.) ■ Ca metabolism abnormality -. @pustular ps. ■ Epidermal keratinocyte proliferation in ps. ■ Immunological aspects of psoriasis ■ Systemic drugs : - Anti malaria(Chloroquine) - Beta-Blocker , - Ca chan. Blocker . ■ Endocrine factors: Hormonal factors ■ Infection (Strept. infection)- @Guttate ps. ■ Ultraviolet radiation and psoriasis . ■ Stress ,smoking , and alcohol .	Etiology:Unknown other theories ■ Stress . ■ Infection: hepatitis B and C . ■ Genetics of lichen planus ■ . Systemic drugs ■ . Immunological aspects .	cause of pityriasis rosea is unknown . HSV-6,7
CLINICAL PICTURE	Classic Lesion:-(see def.) Site:- • Classic lesion =predilection for scalp ,nails ,extensor surface of the limbs , elbows ,knees , and sacral region . • (Koebner phenomenon ⇒ trauma site) ,, • (ps. Inversus ⇒ flexural areas). • (localized postular ps. ⇒ palmoplantar hyperkeratosis). •(Guttate ps. ⇒ chest). Signs:- - Auspitz sign : presence of small bleeding point seen on a psoriatic lesion when scales are removed. - Candle sign (esp. In erythrodermic ps.) - painless removal of scales Types of ps. According to size:- 1- punctate النقطية. 2-Guttate القطرية 3Nummular 4-Discoid/plaqueالعملية	Classic lesion:- (characteristic) , small ,violaceous , flat-topped ,polygonal papules (.fitz. 4Ps.=purple, polygonal, pruritic, papule) With glistening,dry surface ,and scant* ,adherent* scales . With gray or white streaks(wickham's striae) cross the lesions . Size :- begin as pinpoint papules and expand to 0.5 to 1 cm plaques. ■ color • initially- erythematous • well developed lesions- violaceous • Older lesions are often hyper pigmented Site:- predilection for the flexor wrists ,trunk,medial thigh, shine ,dorsal hands , and glans penis, Koebner's phenomenon , may palms and soles Mucous membrane ■ uncommon in face(also ps.) &Uncommon in children(see. Notes below)	■ first clinical lesion : - mother patch(@herald patch) ,(an isolated erythematous patch.) Site :- trunk,(upper chest ,neck) followed up to a week By ■ main eruption of Multiple oval macules . Site :- In trunk ,thighs ,and upper arms . =(proximal of extremities) (hands ,feet or scalp May rarely involved) , (christmas tree distribution , @fine collarate at periphery of macules ■ usually Asymptomatic although there may be mild pruritus .

TYPES & VARIANTS	1■ classic plaque psoriasis 2■ Guttate 3■ Seborrhoeic ,flexural napkin or inversus ■ nail psoriasis!!!! Complicated Psoriasis(4.5.6) 4■ Erythrodermic 5■ Pustular :generalized or localized palmo planter 6■ Psoriatic arthropathy	Variants Linear L. P. Annular L. P. Atrophic L.P. Hypertrophic L. P. Bullous L. P. Ulcerative L. P. 7-Follicular L. P.	
DIFFERENTIAL DIAGNOSIS	(in general.. --see types below) Discoid eczema Seborrhoeic dermatitis Pityriasis rosea Tinea corporis Pityriasis rubra pilaris	• Pityriasis rosea • Psoriasis guttata ■ Mucous membrane : • Lupus erythematosus • candidiasis ■ On the scalp :Cicatricial alopecia	• Secondary syphilis • Drug eruptions (captopril,barbiturate) • p.versicolor • Psoriasis guttate(no collarate scale)
TREATMENT	A- topical therapy:- 1- tar preparations 2- Dithranol preparations 182-- irritant not for complicated case 3- Salicylic acid-(keratolytic to remove scales) 4- Topical steroids- if there is inflammation,,(but long time use ➡Tachyphylaxis) 5- Ultraviolet light B- Systemic therapy: 1- photo chemotherapy (psoralen +UVA) 2-Retinoids group (Neotigason)- for complicat. 3-Methotrexate (Good result,restricted for complicated case due to S.E of drug.) [Initial dose (2.5-5mg)do & follow by blood exam CBC ,, after reach total dose of 1.5g(hepatotoxicity high) --follow by liver biobsy] 4- Biologics(not in our country,expensive) Note, ttt. Not eradicate ps. ,it abort lesion during ttt. Usage.	■ Treatment : TT of lichen planus is difficult . ■ Topical: • Topical steroid ■ Intralesional steroid injections • for (L.p verrucosus) triamcinolone ■ Syst: • Systemic corticosteroid (prednisolone 0.5-1mg/kg)	Treatment: topical steroid . Antihistamin if prurits (if Scratching ➡hyperpigment. ➡cosm otic problem) Large mother patch  2nd eruption  

TYPE	CLINICAL	SITES	DIFFERENTIAL DIAGNOSIS	IMAGES
Types OF PSORIASIS				
Plaque psoriasis	(Classic lesion),	most commonly: extensor aspects of the knees , elbows & scalp.Also, hands & sacral area.	T.corporis eczema Discoid	
Guttate psoriasis :	multiple small psoriatic lesions commoner in children than adults(post strept. Infection (URTI)	mainly on the trunk.	PR PV PRP	
Seborrhoeic psoriasis	classic ps. lesion on the scalp(thick, scaling& redness. Ass. ē less typical erythematous,finely scaling lesion in the body folds(esp. groins ,axillas, and inframammary regions)		Seborrhic.D. erythrasma contact D.	
Nail involvement: (proportion of pt. ē long-standing ps. develop nail changes)	small pits on the nail plate and onycholysis = separation of part the nail from the nail bed . subungual hyperkeratosis		L.planus Onchomycosis	
Localized pustular psoriasis (palmo-plantar pustulosis)	1ry lesion ➔ pustules .	DD. Contact Dermatitis hyperkeratotic Reiter \$ warts T.manum&pedis plane PRP (5disease)		
Generalized pustular psoriasis (Von Zumbusch)	fever and recurrent episodes of pustulation within areas of erythema. rare but serious		- L.planus - seborrhic D. - seizary \$ - Drug eruption	
Erythrodermic psoriasis	extensive erythema of the entire body surface with ,at times!, very few (may d.to removal!!) classical scaling psoriatic lesions	Generalized but More on trunk		
psoriatic arthropathy	in 5% of psoriatics. Distal arthritis involves the terminal interphalangeal joints of the toes and fingers, esp. those ē marked nail changes.	Xray:- Sausage digit &pencil in cup	Rh. Arthritis. SRE \$!!	
Lichen planus subtype				
Linear	Koebner	Koebner phenomena found in (ps. ,L.p ,Plane wart ,Vitiligo...)		
Annular	Annular configuration,	Lips,penis,skin		
Hypertrophic(L.P verrucosus)	Verrucous palque 1ry Lesion:- Nodules	Shins and anywhere	Erythema nodosum Erythema andorutum	

Ulcerative		Rare in skin, common on MM.(much more chronic)	Tropical (aden)ulcer	
Follicular		Scalp	Alopecia areata DLE Cicatricial Alopecia Tenia capitis(keroin) Linear morphae(en coup de sabre) ضربية السيف	
Notes in involment of L.planus	■ mucous membrane:- Oral lesions may be white reticulate(common) ,(DD. Candida) /atrophic or ulcerative (DD. BehÇet ,aphthus vulgaris,gingivostomatitis) • On the lips the papules are often annular , but may be erosive. • On the glans penis - consist of flat , polygonal papules .(DD. BehÇet,2ry syphilis,STD,Lichen.....Atrophicus). • vulvovaginal areas , erosive or ulcerative disease is common ■ Nail changes • in 5% to 10% of patients DD. (PSORIASIS,L.PLANUS,ONYCHOMYCOSIS) • (Longitudinal ridge,thining of nail plate) • subungual papules may cause thickening and malformation of the nails.			■ L.Planus is uncommon in face & if(it <u>confined to the eyelids/ lips / both.& may plaques or small papules</u>) . ■ L.planus is uncommon in children &(Classic lesions - uncommon . & <u>often have affected family members.</u>) 
Actinic L.P ركز عليه د/أيمن بصورة	Most common in Middle Eastern and Indian patients (also Africans); young adults or children; onset in spring or summer on sun-exposed sites (face, forehead > dorsal UE, neck, intertriginous sites); comprised of red-brown annular plaques or melasma-like patches (less common)			

Pityriasis	Pityriasis versicolor (النخالة المبرقشة)	Pityriasis Alba (القحاح بالعامية) النخالة البيضاء	Pityriasis Rubra pilaris
Def.	Mild chronic superficial fungal skin infection	Non specific dermatitis Ch. by erythematous scaly patches.	
Epidemiology	most common in adolescents & young adults , (same ...) common worldwide	More in children , (male, fair skin,)	
Etiology	Malassezia furfur (pityrosporum orbiculare) Malassezia globosa , (fitz. - not contagious, normal inhabitant of body surface) Predisposing factor:- High temperatures / relative humidity , - Oily skin, Hyperhidrosis, - Hereditary factors,- Glucocorticoid treatment, - immunodeficiency.(PV Inversus) -Malnutrition. --Cushing disease.	Un known Predisposing :- Unprotected sun exposure - Skin dryness and change of climate - Poor hygienic habits - unsuitable cosmetic substances / soap - Deficiency of Vit A or copper & Iron - long term cortisone - Hereditary	
Clinical pictures	Skin symptoms Often Asymptomatic /Mild pruritis Cosmetic problem only With ttt. :- Scales end but pigmentation persist for months ▪ Typical skin lesion : Multiple, well-marginated, finely scaly, oval-to-round macules ... coalesce, forming irregularly shaped patches of pigmentary alteration. Site :- scattered over the upper trunk neck upper arm back, abdomen and occasionally face Scales :-fine , dust like(furfuraceous) Color :- hypo- (common) / hyper- pigmentation.	Ill-defined, Hypo pigmented lesion covered with dry, fine scaled, More on the face(Cheeks)	
Diagnosis	Clinical :- characteristic KOH Exam. :-Confirmatory (spaghetti. & meat ball Appearance) Wood's light may yellowish (golden yellow) fluorescence	-ve result by using D.M.E Rull out DD.	
DD.	Hypopigmented PV: - Pityriasis alba, - Vitiligo - Postinflammatory hypopigmentation, - Tuberculoid leprosy. Dd. Of Scaling Lesions - Tinea corporis, - seborrheic dermatitis, - pityriasis rosea, - guttate psoriasis, - nummular eczema	- vitiligo - Pityriasis (Tinea) versicolor - Atopic or Contact Dermatitis -pityriasis Rosea	
Treatment	▪ TOPICAL THERAPY • Selenium sulphide (2.5%) lotion or shampoo. \> • Azole antifungals(ketoconazole 2% shampoo) ! • Zinc pyrithione→....→→→→→→→ • Sulfur- salicylic acid combination • Terbinafine topical ▪ SYSTEMIC THERAPY Indicated 4 pt. e :- (▪ extensive disease, ▪ frequent recurrences, ▪ topical agents have failed) • Oral Ketoconazole(limited Use due to S.E) 200mg daily for 7- 10 day • Oral Itraconazole 200-400mg daily for 3-7days./ 400single dose • Oral Fluconazole200-400 as itraconazole (dr.damag flucoral® 150 2doses separated by 1wk) ▪ Oral Terbinafine not effective ▪ Recurrence is common, • so maintenance by any of topical agents / one tablet a month of azoles is important. • Scales return -	Self limited (spontaneously resolve) Also can use ▪ Low-potency topical steroids (hydrocortisone1%, desonide0.05%) limited up to one month to avoid long-term skin atrophy and steroid changes. ▪ A simple emollient cream ((the main treatment)) ,, Retaining moisture especially if applied immediately after bathing. □ others (not commonly used) ▪Tar paste(not on face) ▪Calcineurin inhibitors ▪Laser therapy: ▪PUVA	



Dermatitis				
	IRRITANT CONTACT D.	ALLERGIC CONTACT D.	PHYTO TOXIC PHYTOD.	PHYTOALLERGIC PD.
Def	Non Immunological localized inflammatory reaction of the skin resulting from exposure to substance that cause irritation or eruption in most people who come in contact with it.	Immunological (type IV) .eczematous (papules, vesicles, pruritic) dermatitis due to re-exposure to substance to which the individual is sensitized.	sunburn produced by wavelengths whose energy would not normally provoke it unless absorbed by a photosensitizer	Photoallergic reactions result from a radiation-induced alteration in a chemical that is sufficient to change its antigenicity
	▪ Every one is susceptible for ICD. ▪ No requirement for prior exposure. ▪ women > men (environmental factors, not genetic factors.) ▪ Severity depend on- Concentration of the irritant. Length and frequency of exposure Skin susceptibility	▪ only sensitized person susceptible. ▪ Requir prior exposure to the same allergen. ▪ younger & females higher ▪ severity depend on Degree of sensitization (not conc. Of allergin) Risk :-Pre-existing skin conditions: as ICD , atopic D. ,Ps. . Cuts /scratches. -Hereditary /Environmental factors:	▪ Every one is susceptible for ICD. ▪ No requirement for prior exposure. ▪ Factors 1. concentration of phototoxic substance. 2. amount of radiation in proper wavelength. (UVA > UVB)	▪ only sensitized person susceptible. ▪ Requir prior exposure to the same allergen.
Etiology	Chemical irritants . Solvents. Acids Soaps and detergents (alkalis) : Rubber gloves Many plant leaves Napkin dermatitis: (urine and feces) Dribble rash Cosmetics : Physical irritants . Dry cold air (low humidity) . Temperature variation: Water. Dusts and gases Plants Airporne irritant contact dermatitis	Metals Cosmetics and dyes Medication Rubber plants Resins	Direct tissue injury Many	Type IV hypersensitivity Many.....
Clinical picture	1- Acute ICD :(<u>single exposure to strong irritant</u>) Rapid (minutes to hours of exposure) well defined,painful edematous ,erythematous ,blisters wheals. (Papules-rare) 2- Sub acute ICD :(<u>Repeated exposure of small area</u>). :erythmatous plaque ē scales & crusting 3- Chronic ICD : (<u>cumulative</u>) take many months or years to appear thickened and hyperpigmented plaque with lichenification .	1- Acute ACD : Not so Rapid (12-72h of exposure) Well-demarcated Itchy erythema & edema ē closely spaced, vesicles, and/or papules , , bullae, erosions, crusts 2- Subacute ACD : Plaques erythema ē small, dry scales . sometimes papules . 3- Chronic ACD : Plaques of lichenification ,scaling with papules, excoriations, erythema, and pigmentation. Arrangement :- <u>Initially confined</u> to site of contact, <u>later spreading</u> beyond. (earlobe (earrings), dorsum of foot (shoes), wrist (watch or watch-band), collar-like (necklace), lips (lipstick)]. Often linear, with artificial patterns, an "outside job"	"Exaggerated Sunburn" ,erythema and edema vesicles ,bulla ,burning/smarming <u>.resolve ē hyperpigmentation.</u> confined exclusively to areas exposed to light. ▫ Lesion variant ▪ Photoonycholysis & subunchal Hge . ▪ Lichnoid eruption : lichen planus-like lesions pigmentation : - marked brown pigment.. ▪ Pseudoporphyria . : (d.dx ē porphyria cutanea tarda) of skin fragility, vesicles, and subepidermal blisters and Telangiectasia&less erythema	.eczematous eruptions,papules, vesicles,scaling,crusting, usually pruritic <u>resolve with erythema</u> <u>&less commonly hyperpigmentation</u> Initially confined but may spread. ▪ difficult to <u>differentiate between</u> photoallergy and ACD(shaded area uninvolved in photoallergic .may of help)

	IRRITANT CONTACT D.	ALLERGIC CONTACT D.	PHYTO TOXIC PHYTOD.	PHYTOALLERGIC PD.
Diagnosis	1- From detailed History which required to identify the causative agent. 2-Patch tests : to confirm or exclude allergic contact dermatitis and identify the allergen. (not exclude irritant contact dermatitis as the two may coexist)	Patch Test - Application of the allergen to any area of normal skin provokes an eczematous reaction. (do it <u>onlys 2 wks</u> after subside.)	Clinical+phototest	Clinical +phototest+photopatch test
Differential diagnosis	-Allergic dermatitis -drug eruption dermatitis -atopic dermatitis -seborrheic dermatitis -discoïd -asteatotic eczema -stasis or venous eczema	ICD Erysipelas Any eczema-like reaction Atopic dermatitis Tinea Contact seborrheic dermatitis (face) psoriasis (palms and soles) Drug eruption phytophotodermatitis	Sunburn, phototoxic reactions due to excess of endogenous porphyrins, photosensitivity due to other diseases, eg, SLE Phytophoto ---Acute ICD	Allergic CD Atopic D. Polymorphic light eruption (PMLE) Actinic prurigo Solar urticaria Porphyrias Photoexacerbated dermatoses
Treatment	Acute dermatitis best treated with • cold moist compresses • high potency (class D)topical corticosteroid creams . ▪ Subacuteand chronic cases can be treated with lower potency (class 2) corticosteroids in ointment base ▪ Emollient creams (to correct dryness and scaling of the skin, and mild irritant contact dermatitis.) ▪ Antihistamine treatments for itching. ▪ Antibiotic , for secondary bacterial infection , (usually flucloxacillin or erythromycin) ▪ calamine lotion (الجسم عدا الوجه) Prophylactic measures:- -Avoid the suspected irritant . -use of protective clothing, and gloves. تكون لما تغسل الاواني بصابون تعمل كفوف قطن وفوقها كفوف ريل وهكذا -Always keep your hands moister after washing .	▪ Acute dermatitis of any sort is best treated with cold moist compresses and high potency topical corticosteroid creams . ▪ More chronic cases can be treated with lower potency corticosteroids in an ointment base -Potassium Permanganate - Calamine Lotion (الجسم كامل عدا الوجه) - Oral antihistamines as diphenhydramine relieve itching - Topical Emollients - Oral antibiotics - Oral glucocorticoids: For severe case . - Immunosuppressant (Oral cyclosporine for -resistant chronic diseases Prophylactic: - avoid the cause - protective measure :-using occlusive gloves with underneath cotton gloves to absorb perspiration. - avoid scratching (cause 2ry infections)	<u>As ttt. Of sunburn (fitz)</u> ▪ Avoid sunburn by (clothing,sunscreenavoid sunbathing) Moderate sunburn ▪ Topical glucocorticoids. ▪ Systemic Acetylsalicylic acid, indomethacin, NSAIDs. Severe sun burn ▪ Bedrest ,or ▪ if toxic pt. →hospitalization for fluid replacement, prophylaxis of infection, et ▪ Topical glucocorticoids. ▪ Systemic-Oral glucocorticoids	Avoid /decrease sun exposure ▪ Identification and avoidance of the causative phototoxic or photoallergic agent . ▪ Topical glucocorticoids and compresses are useful. ▪ systemic glucocorticoids should be reserved for only the most severely affected patients. ▪ In severe cases, immunosuppression (azathioprine plus glucocorticoids)
	Complications : •2ry bacterial infection (Staph. aureus) •cosmetic problems : post inflammatory hyper /hypopigmentation .Scarring if corrosive agent exposure . 3-neurodermatitis.	Steroids Potency with commonly used examples:- ▪ lower potency steroid only 1% hydrocortisone should be used in face &infancy ▪ Moderately potent steroids (eg. 0.05% clobetasone butyrate) clobavate® ▪ Potent steroids (eg. 0.1% betamethason valerate), betnovate® 0.1% mometasone furoate Momicon® cream /lotion ▪ Very potent steroids (eg. 0.05% clobetasol propionate) Dermovit®		

Other type of dermatitis				
Atopic dermatitis				
Seborrheic dermatitis				
Dyshydroti c				
Discoid				
Neuroder matitis				

	Urticaria الشرى	Papular urticaria	Prurigo nodularis	Erythema multiform
Def.	a vascular reaction of the skin . it is a common skin disease characterized by wheals (red* or white) , associated with the sensations of itching* or burning .	= Prurigo simplex acute =(Stropholus) <u>chronic or recurrent</u> papules caused by a hypersensitivity reaction to the bites of mosquitoes and other Insects .	= حكاك عقيدى chronic disease with multiple itching nodules on the extremities, especially on the thighs and legs.	Definition: it is an acute, usually self-limiting reaction in the skin and mucous membrane , characterized by multiform lesions (<u>macules</u> , <u>papules</u> , <u>vesicles</u> , and <u>bullae</u> with iris or target lesion) The central area may blister
Etiology	Drugs: penicillin, Sulfonamides, aspirin. Food: eggs, fish, milk and others. Infections: focal sepsis, viral infections (Hepatitis C), fungal inf. (candidiasis). Parasites (E. histolytica, E. vermicularis, ascaris) esp in child Insect bites. → papular urticaria Physical agents. emotional stress. Alcohol. Pathology:- increased release of histamine from the mast cells situated around the capillaries. → increased capillary permeability, → allow proteins and fluid to extravasate → urticarial wheal	Age: This eruption occurs primarily in children . (Common disease) Cause: Hypersensitivity to insect bites	unknown. Causel factors: 1-Emotional stress 2-Atopic dermatitis 3-Anemia 4-Hepatic disease 5-HIV disease 6-Pregnancy 7-Photodermatitis	Immune-mediated disorder 2 types idiopathic/ 2ry The causes are : 1- Drugs: sulphonamide – barbiturate – B-blocker 2-Collagen disorders: 1. Lupus erythematos 2. Polyarteritis nodosa 3. Infections: -Viral : herpes simplex – hepatitis A, B and C -Bacterial: mycoplasma, Streptococcus. -Fungal: candidiasis. 4. Radiotherapy 5. Malignancy 6. pregnancy
Clinical picture	Urticaria : 1ry :- wheals (reddish or whitish evanescent, slightly elevated edematous lesions of variable shapes and sizes. (Φ Sharply defined, pruritic), transient e transmission of lesion , and last only for a few hours < 24h. (يجي ويروح) Site:- any where (• generalized (trunk, buttock, chest). but may localized). • Angioedema can occur e urticaria or alone, which is - an acute circumscribed (subcutaneous / deeper tissue) edema (No transmission of lesion) - usually affects the most distensible tissues , such as the <u>eyelids</u> , <u>lips</u> , <u>lobes of the ears</u> , and <u>external genitals</u> , or the <u>mucous membranes of the mouth</u> , <u>tongue</u> or <u>larynx</u> ...	Lesion: (1ry = papules) crops of symmetrically distributed pruritic papules* and papulovesicles . <u>Pustules</u> after scratch & ulcers Site:- in an area localized to the site of insect bites (commonly lower leg, hands, abdominal skin). or may generalized Individual papules may surround a wheal and display a central punctum.	• multiple itching nodules on the extremities, esp. on the thighs and legs. • A linear arrangement is common. The individual lesions are larger, and erythematous or brownish . When fully developed they become verrucous , or fissured .	Clinical Picture: 1-E.M Minor. 2-E.M Major. ▪ E.M Minor: commoner & mild form. lesions → mainly cutaneous . characteristically multiforme . One or more of the following lesions may be present: (macules, papules, vesicles, iris, target , Purpuric and urticarial.) Sites:- commonly effected are the face, neck, dorsum of hands, forearms, feet and legs . <u>Mucous membranes are quite severely involved</u> . ▪ E.M major: Severe involvement of the eyes and mucosal surface is termed the Stevens-Johnson Syndrome . (النucleus°) الن يعتبر مرض لحاله <u>Skin lesion</u> :- Exudative membranes (Bullae) are common. Mucous membranes are involved in all cases in the form of extensive bullae formation followed by erosions . Other symptoms are common (fever, arthralgia)
Classification	Classification: By duration :- Acute urticaria:- evolves over days to weeks, < 6w chronic urticaria :- urticaria and/or angioedema lasting more than 6 weeks by pathogenesis : nonimmunologic , immunologic and idiopathic . By types of urticaria : 1- Physical (dermographism , cold, solar, heat, Pressure, vibration, Cholinergic (sweating → small, papular, highly pruritic U.), Aquagenic (v. rare) ▪ Dermographism: most common type of physical urticaria, mast cells releasing extra histamine after rubbing/ scratching → sharply localized edema or wheal with a surrounding erythema			

	(Draw Z In upper back (wheels appear in z shape 5-10min after, and fade e 2-3hours(Φ30min)) 2- Hypersensitivity 3- Pharmacological 4- Contact (dd. ē CD) 5-Autoimmune disease: ass. ē SLE, cryoglobulinemia 6-Genetic: hereditary angioedema is characterized by recurrent attacks of angioedema (Urticaria rarely occurs, no transmission of lesion).			
Dx. +DD.	Diagnosis : clinical. DD: - Transmission of lesion from Allergic C.D drug eruption photo/photophytophotodermatitis (solar U.) heat U. Has hyperhydrosis ⇒ dd(miliaria rubra) Erysipelas - dermatographism ⇒ kobner's phenomena - Duration :- Urticaria vasculitis (>24h) - Urticaria pigmentosa - E.M - Granuloma annulare (from annular lesion) - Sarcoidosis - Angioedema ⇒ ACD	DD: 1- Impetigo 2-Dermatitis Herpotiformis غالبا في مقدمة الرجل 3-Scabies (different localization) 4- Drug eruption	DD: 1-Lichen planus verrucosus. 2-Lichen simplex chronic. (in neck, lower leg)	DD. Drug eruption LE Pemphigoid Toxic epidermal necrolysis (TEN) Dermatitis herpetiformis - Eye & mucous memb (SJS) - SSSS / TEN - p.vulgaris - ocular pemphigus
Treatment	TT. Of urticaria 1- search of the cause. - Food:- كيف؟. يبدأ يوقف الاكلات لكن نرجع نرجعهن . انك تسال المريض يرجع اكل حازه معينه او ياكل مثلا بيض لمدة ثلاث ايام ويشوف اذا ماجاءت معناته مش متحس منها وهكذا مع كل وجبه علشان لا تجوعه هذا بعد ما وقف بقيه الاكلات المشهوره انه تجيب تحسس مثل البيض السمك الشيكولاته المنجه الخوخ - Septic focus , stress , drug - Stool analysis for Parasites 2-Antihistamine therapy with H1. 3-Systemic corticosteroid. short course ©clamyل للجسم كامل عدا الوجه  TT of the angioedema and severe cases: antihistamin I.m (avil®) +steroid I.m dexamethasone=dexafort® 40mg) adrenalin s.c(1 CC)	TT: - Of Cause:- clothing (prevent insect bite) - of pruritis sys- Antihistamin Top-steroid - If scratching - Antiseptic - Topical antibiotics ē steroid (fucicort®=fusidic acid +steroid) - Severe bact. Infection ⇒ Systemic AB	topical: 1-topical steroid 2-Intralesional steroid (Triamcinolone) if verrucous lesion Syst:- Antihistamin	TT: 1. Mild E.M: symptomatic - Antihistamine - Topical corticosteroid 2. Severe EM and S.J. syndrome - prednisolone 20 – 60 mg \day (1mg/kg) - Antibiotics for secondary infection (erythromycin or tetracycline) - Acyclovir for E.M following herpes simplex - Ophthalmologist for ocular involvement.
	Chronic spontaneous urticaria			

Pigmentary lesions	Normal skin color is composed of a mixture of four chromophores, (1) reduced hemo-globin (blue), (2) oxyhemoglobin (red), (3) carotenoids (yellow; exogenous from diet), (4) melanin (brown). Epidermal melanin unit : 1+2 +3 1-Melanocytes 2-Melanosomes 3-Keratinocytes Skin color determined by :- - Different races have Same no. of M. - Constitutive skin color (تحدد الجينات) - Facultative (inducible) skin color (يحدده العوامل البيئية كالتعرض للشمس)	Synthesis of Melanin- Melanocytes, In Skin- hair bulb, dermis, D/E Jun (Mucus membrane) Uveal tract Sterile vasculature Melanocyte Melanosome Tyrosine by tyrosinase converted to Melanin Melanin has Protective function (Cap over the nuclei of keratinocytes) UVR blanket	Disorders of Pigmentation No (Leukoderma) Hypo pigmentation melanopenic hypomelanosis (↓ melanin production, No decrease cells) as (albinism-genetic) melanocytopenic hypomelanosis (↓ melanocyte, lead to ↓ melanin) (vitiligo - autoimmune) Hyper pigmentation Excess Melanin (melanotic hypermelanosis) as lentigo Excess cells (Melanocytotic hypermelanosis) as melasma Hypermelanosis can result from 3 factors: 1- genetic; 2- hormonal (as in Addison disease), when caused by ↑ circulating pituitary melanotropic hormones 3- UVR (as in tanning).
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1- Albinism (melanopenic hypopigmentation)	• Cells normal but Functions abnormal • May Complicated by premature photoaging. SCC Sun burn	• 2 types according to DOPA Reaction	Treatment
		1- Tyrosinase Negative DOPA negative Child born with - Snow-White hair pink white skin - Blue Iris - Retina - + Photo phobia + - Nystagmus + Severe visual retardation	2-Tyrosinase positive (most common) - DOPA Positive - some manifestation, less apparent - No visual disturbances



PIEBALDISM (Melanocytopenic)	Hereditary Melanocytopenic hypomelanosis Congenital Autosomal dominant resulted from defect in differentiation or migration of melanoblasts. Started at birth No melanocytes	Depigmented area with Pigmented area White forelock - Medial parts of brows are white - Eye lashes depigmented - Chest abdomen Limbs Face	Treatment - Sun protection - Depigmentation- By (20% monobenzy either hydroquinone)	
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	Post-eruptive hyper-pigmentation 1- Pemphigus, 2- Dermatitis Herpetiformis, 3- Lichen planus, 4- Eczema, 5- Morphea and systemic sclerosis.	Post-eruptive hypo-pigmentation 1- Pityriasis Rosea, 2- Pityriasis Versicolor, 3- Pityriasis Alba, 4- Seborrheic Dermatitis, 5- Psoriasis, 6- Leprosy, 7- Secondary stage 8- Syphilis.		
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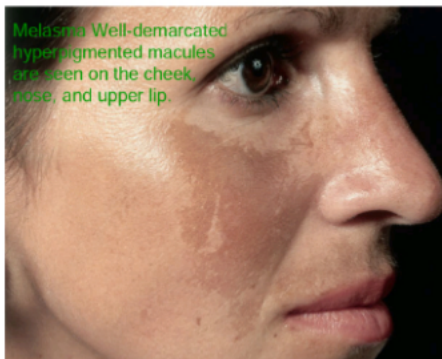
Vitiligo Image

Vitiligo: face convex borders chalkwhite color and sharp margination.

Vitiligo: knees. Depigmented, sharply demarcated macule on the knees, symmetry. The tiny follicular pigmented spots within the vitiligo areas that represent repigmentation.



Vitiligo Hereditary Melano -cytopenic. Localized or Generalized. (Vision is unaffected. Hearing is normal.)	Etiology:-Theories:- 1) Auto-Immune (steroid may help) 2) Neural concept (neural mediators) 3) Self - Destruction (toxic substance in melanine formation pathway) 4) psychological factor (طفل يفار من أخوه، وكمان أحياناً يكون ظهوره بعد تعرض الشخص لصدمه نفسيه وهذا معروف عند العامه تساله ليش وقع لفلان بهي يقول لك وقع له فجيعه، خوف شديد) 5- Loss of growth factor in melanocytes. Pathology:- - No melanocytes + Lymphocytes around superficial blood vessels. Associated Abnormalities - ocular disorders - Autoantibodies, - Diabetes Mellitus 1-7 of patient - Disorders of thyroid gland. • Psoriasis. • Scleroderma • Alopecia Ecreata Vogt-Koyanagi-Harada syndrome is vitiligo + poliosis + uveitis + dysacusis + alopecia areata.	Incidence:- - All races, any age. M.=F. - 5% before 20 years. (50% begin in 10-30y) - 30% family history positive. C/P:- - Disfigurement + Sun burn in - Sun exposed areas. - Areas Liable to trauma - Around body orifices. - Hyperpigmented areas - Koepner's. Morphology:- (progressive, acquired, chalk-white, bilateral (usually symmetric), sharply defined macules in typical sites) Dr. (Depigmented irregular variable in size & shape. Diagnosis) - Hair: -Color may be white. - Margin may be hyperpigmented	Course Unpredictable Management 1) Topical:- Sunscreens with a sun protection factor >30 Cosmetic cover-up (contain dihydroxyacetone) Local chemotherapy (puva) → for local macules. Topical steroids → (4wk on 2wk off) If no repond in 1st 2mo. → no benefit Topical tacrolimus (only sun exposed area. 2) General:- - Systemic photochemotherapy (PUVA) need 1 year (85% effective in 70% pt) (Trimethyl psoralen + 8 Methoxy psoralen + Khellin Khellin 0.6 mg/kg.) (note 8-methoxysalen = ultramelinine • يستخدم مراتين باليوم وتكون تعرض نفسك للشمس في الشروق والغروب خمس او عشر دقائق بس وبعدين لا تخرج في الشمس ولا تبقه ولو بتخرج تغطي جسمك وتعمل واقي شمس ونظارات شمسية، ولا تغسل بماء دافئ) - Systemic steroid / Intralesional steroid:- dexamethasone / prednisolone (Hostacortine tab 5mg 1x 3) - Vit. B analogus Narrow-band UVB → treatment of choice in children <6 years of age. Excimer laser → best results in the face. - Depigmentation إنه يزيلوا المناطق الطبيعيه عشان يكون كله لون واحد غالباً يعملوه اصحاب البشره السوداء Bleaching of normally pigmented skin with <i>monobenzylether of</i> hydroquinone 20% (MEH) cream is a permanent, irreversible process. - Placental extract (Cuba) - Topical MSH - melanocyte transplantation for acrofacial resistant (need 1 month at least with no new lesion) Note on PUVA → During PUVA do :- - Sun screen - Sun glasses - No erythema - Gradually Increase the dose - Not before 10 years/pregnant	DD. Pityriasis alba (slight scaling, fuzzy margins, offwhite). Pityriasis versicolor (fine scales with greenish-yellow fluorescence under Wood lamp, positive KOH. Chemical leukoderma . Leprosy (endemic areas, off-white color, usually illdefined anesthetic macules Tuberous sclerosis (stable, congenital off-white macules polygonal, ash-leaf shape, - occasional segmental macules, and confetti macules postinflamm. Hypopigmentation
	Types: - Localized -Focal → Ch. by one or several macules in a single site - segmental → usually on one unilateral region; very stable; may assoc. E other types - Generalized - Acrofacial (lip-tip) → skin around the mouth, distal fingers and toes; lips, nipples, genitalia (tip of the penis) & anus may involved; poorly respond to ttt. - Valgais → - universals → (لما يكون الجسم كامل عدا فقط مناطق قليله) - Mixed - Special types Trichrome → (three colors: white, light brown, dark brown) represents different stages in the evolution of vitiligo Halo nevus			
Melasma	Common acquired hypermelanosis Exacerbation:- - Sun - Pregnancy - Contraceptives - Antiepilepsy drugs - Psychological causes. - More common in women child bearing & 10% in male. - Less in post menopausal with estrogen treatment	C/P:- Well-demarcated hyper pigmented macules/patch Site:- Centro facial cheeks, forehead, u. lip, nose and chin. Course and prognosis:- - Increased by sun + artificial light - UVA / UVB - Slowly resolved after child birth and if we stop pills 2 types - epidemic - B-Deep-dermis (thick pigment أو وحشهم)	Treatment (Dependable) Sun blocks. SPF > 30. (potent transparent sunscreen) Bleaching - 2-4% Hydroquinone - 0.025 Tretinoin - 1% Hydrocortizone / mometasone • May Combination (not for pregnant) - TCA (trichloroacetic acid) -- للجلد الفاتح -- للجلد الشوية غامق - Glycolic acid -- للجلد الشوية غامق - Azelaic Acid 20% Time Two- Six months - not use ethers of hydroquinone (permanent & stellate hypopigmentation)	DD. Actinic lichen planus



Melasma Well-demarcated hyperpigmented macules are seen on the cheek, nose, and upper lip.

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